CARE/HIPP
Client Disclosure

The following statements of policy and eligibility criteria apply to **all applicants**. **Please Read and Initial each statement.** Any questions should be referred to your benefit counselor before signing this document. The original of this document must be maintained in the client's file.

ELIGIBILITY

To be eligible to apply for CARE/HIPP the client must demonstrate:

___Assets that do not exceed $6000.00
___Application to Medi-Cal or proof of financial ineligibility for Medi-Cal based on proven excess assets
___HIV-related disability, or is an adult dependent with HIV related disability covered by Health insurance of another person
___Coverage under a health insurance policy that is at risk of cancellation
___Eligibility to continue health insurance under COBRA, or equivalent insurance coverage (private policy)
___Policy holder must be unemployed or employed part-time for reasons related to HIV
___Income at or below 400% of the current federal poverty level
___Health insurance coverage of outpatient prescription drugs, and does not exclude HIV treatment.
___Proof of application for public or private disability benefits
___Proof of appeal of any denial of public benefits, or be in the process of appeal
___No previous denials for services specific to HIV disease

GENERAL POLICIES

___No deductible or co-pay will be paid through this program
___If either policy or coverage is changed, client must immediately notify Benefits Counselor
___CARE/HIPP will not pay for the State's Major Risk Medical Insurance Program (MRMIP)
___Applicant cannot be receiving assistance through AIDS Drug Assistance Program (ADAP) for medications that can be covered through health insurance policy
___Dependents may maintain coverage after death or departure from the program of the primary beneficiary for the balance of the quarter or 1 month, whichever is longer
___Applicant must apply for Medi-Cal if and when assets do not exceed $2000.00
___All refunds of premiums that were paid by the state on behalf of the applicant must be signed over to the State of California. (Refund checks should be made payable to California Department of Public Health, and should be identified with the insured's full name, the policy number or social security number, and the months to which the refund should be credited.)

IMPORTANT: Please note that in order to comply with the Federal Privacy Act (42USC. Section 552a) your social security number and any information you provide may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Under Welfare and Institutions Code, Section 14100.2, any submitted information is considered confidential.

DECLARATION: In signing, I declare that I meet all eligibility requirements, and that I am not enrolled in the AIDS Drug Assistance Program (ADAP) to obtain outpatient prescription drugs that can be covered by private health insurance. I have thoroughly read and understand the provisions of this program and understand them. I understand that my health insurance premiums may be paid as long as I am eligible, until I enroll in the Medi-Cal HIPP program, become eligible for Medicare, or up to 36 months, whichever comes first. I agree to **immediately** notify the benefits counselor of any changes in my circumstances which affect program eligibility or health insurance status.

AUTHORIZATION TO OBTAIN INFORMATION: I hereby authorize _____ and the California Department of Public Health to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made on my behalf, which may be used to determine if the Department will pay health insurance premiums for continued coverage.

Signature of Client _____ Date _____

Signature of Policy holder (if different) _____ Date _____